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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 9 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

34345

State File No.

Registration District No. 47 — Primary Registration District No. 3008 — Registrar's No. 331

1. PLACE OF DEATH:
(a) County Calloway
(b) City or town Fulton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital no 1 2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 28 days
In this community 28 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Howard
(c) City or town Fayette (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Reed
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex male
5. Color or race colored
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Caddie Reed
6. (c) Age of husband or wife if alive DK years
7. Birth date of deceased Feb (Month) 22 (Day) 1892 (Year)

8. AGE: Years 51, Months 7, Days 19. If less than one day ___ hr. ___ min.

9. Birthplace Houston Co (City, town, or county) Texas (State or foreign country)
10. Usual occupation Minister
11. Industry or business
FATHER 12. Name Abe Reed
13. Birthplace Texas (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Nora Murphy
15. Birthplace Texas (City, town, or county) (State or foreign country)
16. (a) Informant Mrs William Reed
(b) Address Fayette Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-15-43 (Month) (Day) (Year)
(c) Place: burial or cremation Fayette Mo
18. (a) Signature of funeral director [signature]
(b) Address Columbia Mo
19. (a) 10-12 1943 (Date received local registrar) (b) Josie Morgenkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 11 year 43 hour 10 minute 55 a M.
21. I hereby certify that I attended the deceased from Oct 1, 1943, to Oct 11, 1943; that I last saw him alive on Oct 11, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Fractured Skull	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

195 / 99 / 1

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident in fight
(b) Date of occurrence Oct 11 43 | 814
(c) Where did injury occur? State Hosp no 1 Fulton Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Forman Thomas (M. D. or other)
Address Fulton Mo Date signed 10 12 43

1141

(Licensed Embalmer's Statement on Reverse Side)

FEB 21 1944

NOV 9 1942

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ~~was~~ will be embalmed by me, or by ....

...., Registered Apprentice No. ....,

working under my personal supervision.

Signed Stuart P. Parker

Licensed Embalmer No. 2900e

P. O. Address Columbia Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.